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Supreme Court, U.S.
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No._____

In The

Supreme Court of the United States

SALLE A. CONOVER,

Petitioner,

v.

AETNA US HEALTHCARE, INC.,
and AETNA LIFE INSURANCE COMPANY

Respondents.

Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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69 pp

QUESTIONS PRESENTED

1. Is Oklahoma's common law state tort claim for insurance bad faith saved from pre-emption under the terms of the saving clause of the Employee Retirement Income Security Act of 1974 ("ERISA'), ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

2. If Oklahoma's common law state tort claim for insurance bad faith is saved from ERISA pre-emption, do the remedies it provide conflict with ERISA's remedial provisions, ERISA § 502, 29 U.S.C. § 1132 so that it would nonetheless be pre-empted.

PARTIES

The Petitioner is Sallee A. Conover ("Conover').

The Respondents are Aetna U.S. Healthcare, Inc. ; and Aetna Life Insurance Company ("Aetna').

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PETITION FOR A WRIT OF CERTIORARI

Conover respectfully submits that a writ of certiorari should issue to review the judgment of the Court of Appeals, Tenth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals is found at 320 F.3d 1076 and reprinted in the Appendix ("App.') at Page 1a. The opinion of the lower court is published at 167 F.Supp. 2d 1317 (N.D. Okl. 2001). The Order Denying plaintiff's petition for rehearing and rehearing *en banc* is found at Page 9a.

JURISDICTION

The United States Court of Appeal's Order denying Conover's petition for rehearing and petition for rehearing en banc was filed on March 21, 2003. This petition is being timely filed within 90 days of that date. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the following statutes: 29 U.S.C. §§ 1001; 1132; and 1142 set forth at App. 10a to 26a.

STATEMENT OF THE CASE

A. INTRODUCTION

In 1987 this Court rendered its opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). In that case this Court analyzed the Mississippi bad faith law and determined that it was a law of general application that impacted on the insurance industry rather than a law that was specific to the insurance industry and was regulatory in nature. In doing so, the Court reviewed the heritage of Mississippi's contractual bad faith law and found that it had its roots in general contractual law. Petitioner believes that such an analysis under the rigid McCarran-Ferguson test applied in *Pilot Life*, the modified McCarran-Ferguson set out in *Unum Life Ins. Co. v. Ward*, 526 U.S. 899 (1999) or the most recent test adopted in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. ___, 123 S.Ct. 1471 (April 2, 2003) would have a different result if the subject was Oklahoma's insurance bad faith laws.

This is precisely what the Honorable Sven Eric Holmes did in the case of *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F.Supp. 2d. 1202 (N.D. Okla. 1999). Because space will not allow a full review of this issue, we implore the Court to read Judge Holmes' opinion. Also, Judge Holmes is so confident in his position that he has certified a question on the issue to the Oklahoma Supreme Court.

After this Court decided *Pilot Life*, it appears that virtually all of the courts throughout the United States, both at the district level and at the appellant level, believed that the question of availability of a state insurance bad faith claim was foreclosed. The Seventh Circuit even upheld sanctions for one seeking state court remedies in an ERISA case. In *Smith v. Blue Cross and Blue Shield of Wisconsin*, 959 F.2d 655 (Wis. 7th Cir. 1992), the Court determined, "This action

encompasses a classic violation of Rule 11. No reasonable attorney having read *Pilot Life* and *Taylor* could manufacture a good faith argument as to why this suit should be brought.' At 659.

Yet there has been a scattering of district courts that have listened to these "frivoulous arguments' and like Judge Holmes in *Lewis v. Aetna* determined that the state insurance bad faith law that was being examined was saved from ERISA pre-emption. In addition to Judge Holmes' opinion, we have the case of *Hamilton v. United Healthcare of Louisiana, Inc.*, 2001 W.L. 536300; *Selby v. Principal Mutual Life Ins. Co.*, 2000 W.L. 178191 (S.D.N.Y. 2000); *Colligan v. UNUM Life Insurance Co. of America*, 2001 W.L. 533 742 (D. Colo. 2001); *Gilbert v. Alta Health and Life Ins. Co.*, 122 F.Supp. 2d 1267 (N. D. Ala. 2001); *Norman v. Paul Revere Life Ins. Co.*, 2000 W.L. 33316829 (W.D. Was. 2000) and *Rosenbaum v. UNUM Life Ins. Co. of America*, 2002 W.L. 1769899, 28 Employee Benefit Cas. 2002 (E.D. Pa. 2002).

In the case of *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), a three judge panel discussed four (4) post-*Pilot Life* cases decided by this Court and then stated,

> "If we were writing on a clean slate, or deciding this *en banc*, the Roarks would have a strong case against ERISA preemption. But, as a panel, we are bound by *Corcoran*, accordingly, we affirm with respect to the Roarks.' At 307.

Thus, we have one appellant court finding that the mere bringing of a state court cause of action in an ERISA context is sanctionable under Rule 11 and then we have other courts looking at the state law with new eyes and determining they meet the saving clause requirements.

This Court has made three important and significant decisions since *Pilot Life*. The first was *UNUM Life Ins. of America v. Ward*, 526 U.S. 358 (1999). It is the less rigid application of the McCarran-Ferguson that most of the courts above use in determining that the applicable state bad faith law was saved from ERISA pre-emption. That case also called into question whether the discussion in *Pilot Life* regarding conflict pre-emption was part of the holding or merely *dicta*. In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Court made it clear that the discussion in *Pilot Life* regarding conflict pre-emption was simply *dicta* and found it unnecessary in that case to turn that *dicta* into a holding.

A review of the opinion that is being appealed from treats the *Pilot Life dicta* as a mandatory holding. Indeed, a review of the opinion will indicate that a good portion of it is based upon this conflict pre-emption analysis.

Although this Court has declared part of *Pilot Life's* reasoning *dicta* and abandoned the test utilized by the *Pilot Life* court for another, the *Pilot Life* case continues to affect ERISA jurisprudence more than any other case.

B. FACTUAL BACKGROUND

Plaintiff Sallee Conover was employed by Harcourt General, Inc. Group who had a "certificate of coverage' with the defendant Aetna U.S. Healthcare that included, among other benefits, disability insurance. On November 12, 1997, the plaintiff was involved in an accident that rendered her totally disabled. She was certified as disabled on July 13, 1998. Based upon a functional capacity evaluation, it was determined that she could perform the material duties of her occupation with her employer. Plaintiff was notified of the suspension of her benefits on August 6, 1999. Plaintiff maintained that she continued to be disabled.

C. TRIAL COURT PROCEEDINGS

Petitioner filed a suit in the district court of Tulsa County, State of Oklahoma, alleging breach of contract and insurance bad faith. That suit was removed to federal court. At the regularly scheduled case management conference the trial court ordered briefing on two issues - - Whether ERISA pre-empts plaintiff's state law claims and whether a jury trial is permitted. The Court ruled on these preliminary issues in the published opinion of *Conover v. Aetna U.S. Healthcare, Inc.*, 167 F.Supp. 2d 1317 (N.D. Okl. 2001) that the plaintiff's state bad faith insurance claim was pre-empted by ERISA. Judge Brett's opinion indicates why this Court needs to address the issues presented. The Court stated in his opinion:

> "[t]he pertinent issue in determining whether plaintiff's state law claims are pre-empted is whether the United States Supreme Court in *UNUM Life Ins. Co. of America v. Ward,* 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed 2d 462 (1999) alters the binding precedent of *Gaylor v. John Hancock Mutual Life Ins. Co.,* 112 F.3d 460 (10th Cir. 1997).' At 1318.

The Court went on to state that *Gaylor* held that Oklahoma's bad faith law did not sufficiently regulate insurance that it would fall within ERISA's saving clause and in holding the court applied the test set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) indicating that the analysis was based on the three McCarran-Ferguson factors. Judge Brett further recognized that Judge Holmes of the same court held in *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F.Supp. 2d 1202 (N.D. Okla. 1999) that the UNUM test superceded or altered *Gaylor's* holding that Oklahoma's bad faith law is pre-empted by ERISA. The Court went on to state:

> "[w]hile the Tenth Circuit in *Gaylor* applied a less

> 'supple' test in its analysis of Oklahoma's bad faith rule that applied in *UNUM* to the California's Notice-Prejudice Rule, the court is not persuaded the *Gaylor* test is enough at odds with *UNUM* to free the court from *Gaylor's* dictates.' At 1320.

Interestingly enough in his opinion at Footnote No. 6, Judge Brett states as follows:

> "The court questions the relevance of a conflict with the civil enforcement provisions of ERISA in a state-law exemption analysis. Under ERISA, a state law which regulates insurance is expressly exempted from pre-emption. ERISA does not dictate a state law which regulates insurance is exempt *unless* it provides a state law cause of action or remedy. *See UNUM,* 526 U.S. at 377 N.7, 119 S.Ct. 1380 (discussing but not deciding the issue).' At 1320, N. 6, (Emphasis Court's).

After the court's ruling, the parties settled the contractual claim with the plaintiff's right to pursue appeal on the dismissed causes of action.

D. APPELLATE PROCEEDINGS

Conover appealed the dismissal of her state cause of action for insurance bad faith as well as her quest for a common law remedy.

The petitioner presented the same argument that was presented to Judge Holmes in the *Lewis v. Aetna, supra,* case. However, the three judge panel, like Judge Brett, found that they were bound by the decision in *Gaylor, supra.*

> "This Court addressed this issue in *Gaylor v. John Hancock Mutual Life Ins. Co.,* 112 F 3d. 460, 466 (10th Cir. 1997), holding 'Oklahoma's bad faith does

> not sufficiently regulate insurance such that it falls within [the Act]'s saving clause.' We are bound by this decision. *See Burlington N. & Sante Fe Ry. Co. v. Burton,* 270 F.3d 942, 947 (10th Cir.) *cert. denied,* 436 U.S. 959, 112 S.Ct. 2664, 153 L.Ed. 2d 838 (2002).' At 1079.

The most disturbing part of the opinion, however, deals with the court's analysis of the conflict pre-emption issue. This case was briefed prior to this Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 112 S.Ct. 2151 (2002). The *Conover* court stated, "[a] state law otherwise regulating insurance within the meaning of Section 514(b)(2)(A) may still be pre-empted if it allows plan participants and beneficiaries 'to obtain remedies under state law that Congress rejected in [the Employee Retirement Income Security Act].' At 1078. The Court cited *Pilot Life, supra,* and *Rush Prudential, supra,* as authority for this. The Court went on to state in Footnote No. 2 as follows:

> "Miss Conover suggests the Supreme Court impliedly overruled this portion of *Pilot Life's* decision in *Ward*, 526 U.S. at 376, N. 7, 119 S.Ct. 1380. We disagree for three reasons. First, the Supreme Court instructed us to avoid concluding its 'more recent cases had by implication, overruled an earlier precedent' *Agostini v. Felton,* 521 U.S. 203, 237, 117 S.Ct. 1997, 138 L.Ed. 2d 391 (1997). Rather, we 'should follow the case which directly controls, leaving to [the Supreme] court of overruling its own decisions.' *Id.* (Quotation marks and citations omitted). Second, the court in *Ward* noted but did not address the solicitor general's argument that *Pilot Life* does not hold a state law regulated insurance is nevertheless pre-empted if it provides a state law cause of action or remedy. *See*

> *Ward,* 526 U.S. at 376, N. 7, 119 S.Ct. 1380. Third, the Supreme Court reaffirmed this portion of the *Pilot Life* decision in a later decision, stating a state law is pre-empted if it '**allows plan participants to obtain remedies . . . that Congress rejected [the Employee Retirement Income Security Act**]. *Rush Prudential,* 122 S.Ct. at 2165 (Quoting *Pilot Life,* 481 U.S. at 54, 107 S. Ct. 1549.' 1079 Fn. 2. (Emphasis added).

The quotation from *Rush Prudential* is incomplete. The full quotation is "[a]lthough we have yet to encounter a forced choice between the Congressional policies of exclusive federal remedies and the 'reservation of business of insurance to the states, ' *Metropolitan Life,* 471 U.S. at 744, N. 21, 105 S.Ct. 2380, **we have anticipated such a conflict with the state insurance regulation losing out if it allows plan participants to obtain remedies . . . that Congress rejected in ERISA,"** *Rush Prudential*, 122 S.Ct. at 2165 (Emphasis added, Fn 2 of the *Conover* opinion).

REASONS THE PETITION SHOULD BE GRANTED

1. THE SAVING CLAUSE IS AN INTEGRAL PART OF THE ERISA STATUTE AND IT IS TIME TO DETERMINE IF ALL STATE INSURANCE LAWS ARE SAVED FROM ERISA PRE-EMPTION.

In the case of *Metropolitan Life Ins. Co. v. Massachusetts*, 107 S.Ct. 2380, 85 L.Ed 2d 728 (1985), this Court discussed the history of both the pre-emption clause and the saving clause as they moved through Congress and then made this declaration at Footnote 29 of the opinion, "The change gave the insurance saving clause a much more significant role, **as a provision that saved an entire body of law from the sweeping general pre-emption clause."** 85

L.Ed 2d at 744 (Emphasis added). The Court went on to state in the body making this declaration,

> "We therefore decline to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it. If a state law 'regulates insurance,' as mandated-benefit laws do, it is not pre-empted. Nothing in the language, structure or legislative history of the Act supports a more narrow reading of the clause, whether it be the supreme judicial court's attempt to save only state regulations unrelated to substantive provisions of ERISA, or the insurer's more speculative attempt to read the saving clause out of the statute.' 84 L.Ed 2d at 744.

Despite this declaration a significant portion of the entire body of state insurance law that was saved has been pre-empted by what now appears to be *dicta* in the case of *Pilot Life, supra.*

In the 1974 U.S. Code and Administrative News, in its final report the Committee stated as follows:

> "The enforcement provisions have been designed specifically to provide the secretary and the participants and their beneficiaries with broad remedies for redressing or permitting violation of the Retirement Income Security for Employees Act as well as the amendments made to Welfare Pension Disclosure Act. **The intent of the committee is to provide the full range of legal and equitable remedies available both in state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law for recovery of**

benefits due to participants." 1974 U.S. Code and Administrative News, Page 4655.

In *Metropolitan Life Ins. Co., supra*, this Court declared, "[t]he presumption is against pre-emption and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope.' *Metropolitan Life Ins. Co.*, 471 U.S. at 741.

In regard to insurance law, we not only have a law that is traditionally one reserved to the states but one the ERISA statute specifically saves.

Congress conferred jurisdiction on both state and federal courts for actions brought by plan participants and beneficiaries to collect benefits. 29 U.S.C. § 1123(e)

We have already discussed the fact that a three judge panel of the Fifth Circuit believes that these types of actions might be saved if they were allowed to review the case either *en banc* or were not bound by prior precedents.[1]

In the case of *Arana v. Oschner Health Plan, Inc.*, 302 F. 3d 462 (C.A. 5 2002), another Fifth Circuit panel remanded a case back to state court because the defendant sought relief that was unavailable under ERISA § 502(a)

It simple appears that there is no consensus on what the status of the law is at this particular point. Some courts feel that the decisions of this Court after *Pilot Life* have changed the law enough that they are no longer restrained by prior precedent that relies solely on the *Pilot Life* decision. Other courts see merit in the arguments offered in support of the proposition that some state insurance laws might be saved but feel they are restrained by prior precedent that relied on *Pilot*

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[1] *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002).

Life. At least one court thinks that the pursuit of a state law bad faith claim is sanctionable under Rule 11. Obviously, there is enough confusion and this is a question of such importance and there is so much litigation going on regarding this issue, this Court should grant certiorari.

2. THE PRE-EMPTION OF SAVED STATE INSURANCE LAW THAT PROVIDES REMEDIES AND SANCTIONS FOR IMPROPER WITHHOLDING OF BENEFITS DEFEATS THE VERY PURPOSE FOR WHICH ERISA WAS PASSED.

In *Bast v. Prudential Ins. Co.*, 150 F.3rd 1003, 1005 (9th Cir. 1998) *Cert. Den.* 120 S.Ct. 170 (1999), the Court stated, "Although this case presents a tragic set of facts, the district court properly concluded that under existing laws the Basts are left without a remedy.' In that case Rhonda Bast was diagnosed with a secondary malignancy in her left lung. Her oncologist recommended that she undergo an autologous bone marrow transplant procedure ("ABMT'). Prudential informed the oncologist that her bone marrow transplant was not covered by the plan on September 13, 1991. With the help of an attorney and her doctors, Prudential finally relented and on February 28, 1992, approved the ABMT procedure. The spread of the cancer disqualified her for the ABMT and her health declined. She died in January 1993.

In *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1331, 1338 (5th Cir. 1992), the Fifth Circuit said, "The result ERISA compels us to reach means the Corcorans have no remedies state or federal, for what may have been a serious mistake.' The serious mistake in that case included not giving Florence Corcoran temporary disability benefits for the remainder of her pregnancy despite her doctor recommending she have complete bed rest during the final months of her pregnancy. Again, the benefits were denied

after a second doctor reviewed Mrs. Corcoran's medical records and suggested "The company would be at considerable risk denying her doctor's recommendations.' At 1322. During a period of time when no nurse was on duty, the fetus went into distress and died.

In *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49, 52-53, 56 D.Mass. 1977, the Court noted, "The tragic events . . . cry out for relief. . . . ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans. It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong?' The facts that prompted the trial court to ask that question of what went wrong is that Richard Clarke drank to excess. He had a benefit that allowed enrollment in a thirty day treatment center. That benefit was denied three separate times. On the third, Travelers "incredibly refused to authorize . . . a private admission' At. 52. While in a county facility, he was forcefully raped and sodomized by another inmate in his unit. He received little in way of therapy or treatment and less than a month later, he committed suicide. All of this after being denied a defined policy benefit.

In the case of *Florence Nightingale Nursing Serv., Inc. v. Blue Cross and Blue Shield*, 832 F.Supp. 1456, 1457 (N.D. Ala. 1993), *Aff'd.* 41 F.3d 1476, 11th Cir. 1995, the Court stated, "This Court is willing to believe that ERISA has lurking somewhere within it redeeming features.' In that case, no one died, the insurance company simply wanted to pay a ridiculous and arbitrary amount for the services of nursing personnel doing jobs most of us could not stomach.

Finally, in the Tenth Circuit we have the case of *Cannon*

v. Group Health Serv. of Oklahoma, Inc., 77 F . 3rd 1270, 1271 (10th Cir. 1996), stating, "Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted we conclude that the law gives us no choice but to affirm' the grant of summary judgment to the insurer.' This is another case where the carrier denied ABMT to a leukemia patient. This time because it was declared experimental. The decision was reversed over a year later but too late. She died.

Thus, in these cases we have two women dead of cancer, a hopeless alcoholic committing suicide because he was refused a defined benefit that he obviously needed, a dead baby and a health care provider trying to get a proper wage. What these cases demonstrate is that if you withhold the benefit long enough until the beneficiary dies, then you do not have to pay anything. It will be argued in a moment that the only way ERISA can work the way it was designed to work is in conjunction with saved state insurance law. Indeed, ERISA does not purport to regulate insurance at all. As the law now stands, an insurance company that underwrites employee benefits and makes claims determinations does so without any regulation whatsoever. This Court all but said as much in the case of *Pegram v. Herdich* , 430 U.S. 211 (2000).

3. OKLAHOMA'S BAD FAITH LAW IS SAVED FROM ERISA PRE-EMPTION

In *Christian v. American Home Assur. Co.*, 1977 Okl. 1471, 577 P.2d 899., the Oklahoma Supreme Court expanded the *quasi* contractual tort of insurance bad faith extending it to all first party claims and expanding the type of damage that can be recovered. First, the Oklahoma Supreme Court in *Christian* recognized that it was merely an extension of already existing law, not based on general contract principals

but based on the special relationship between an insurer and an insured. In extending the obligation of good faith and fair dealing to all insurance contractual situations, the Oklahoma Supreme Court stated as follows:

> "[12] We have previously held that insurance companies have a duty to act in good faith and fair dealing with their insureds when handling claims made against insureds by third parties. For the breach of this duty, we have imposed liability against the insurer for amounts in excess of the policy limits. *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co.,* Okl., 321 P.2d 685, (1958); *National Mutual Casualty Co. v. Britt*, 203 Okl. 175, 200 P.2d 407 (1948).' At 902.

Thus, we see that the law of *Christian* has its root in prior insurance law and not general contractual law. A review of *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co.,* 1957 Ok 287, 321 P.2d 685, (1958) and *National Mutual Casualty Co. v. Britt,* 203 Okl. 175, 200 P.2d 407 (1948), show that it is the special relationship between insurer and insured that creates that relationship. Indeed, the Oklahoma Supreme Court discussed that relationship back in 1948 when it stated as follows:

> "Their relations became mutually fiduciary; and each owed the other the duty of upmost good faith in their dealings together, and in exercising the privileges and discharging the duties specified in and incident to the policy contract. The plaintiff (insured) engaged to cooperate with the company if a loss threatened. He was bound to do so honestly and with all good fidelity. The company was equally bound to so handle the *Rule* case [*Rule v. Johnson*, 104 Vt. 486, 162 A. 384]. It had a right to look after

its own interest, but it was bound to have due regard for the plaintiff's interests as well.

An insurer . . . is bound to give the rights of the insured at least as much consideration as it does its own in determining whether or not to affect a settlement.' *National Mutual Cas. Co. v. Britt,* 203 Okl. 175, 200 P.2d 407, 411 (Okl. 1948).

Secondly, the purpose of *Christian* is to regulate the insurance industry. It homes in on the insurance industry and we see this from the following quotation:

"[11] We have recognized the *quasi*-public nature of insurance companies and the need to subject the companies to state control for the protection and benefit of the public. *Oklahoma Benefit Life Ass'n v. Bird*, 192 Okl. 288, 135 P.2d 994 (1943). Perusal of our insurance code, Title 36 Oklahoma Statutes, reveal extensive government regulation of the industry in this state.' At 902.

The *Christian* cause of action is one that is directed solely to the insurance industry in an effort to regulate the insurance industry.

On numerous occasions Plaintiffs have sought to extend the *Christian* cause of action to settings and relationships other than that between insurer and insured. In the case *Rodgers v. Tecumseh Bank*, 1988 Okl.36, 756 P.2d 1223, the Supreme Court refused to apply the doctrine in a situation between a lender and a bank. In doing so, the Court stated as follows:

"In their primary allegation of error, the borrowers urged the court, principally on public policy grounds, to extend to this debtor-creditor relationship our holding in *Christian v. American Home Assurance*

> *Co.* In that case we stated, 'An insurer has an implied duty to deal and act in good faith with its insured and the violation of this duty gives rise to an action in tort for which consequential and, in proper cases, punitive damages may be sought'.
>
> While *Christian* dealt with group disability insurance contracts, in *McCorkle v. Great Atlantic Insurance Co.*, we extended the implied-in-law duty of good faith and fair dealing to include all types of insurance contracts. However, we refuse to extend this duty to strangers to the contract in *Timmons v. Royal Globe Insurance Co.*, and *Christian* and its progeny, thus far, only apply against insurers.' At 1225.

Likewise, in the case of *First Nat. Bank and Trust v. Kissee*, 1993 Ok. 96, 859 P.2d 502, the Oklahoma Supreme Court re-emphasized its position that a *Christian* cause of action does not apply to other contractual relationships. It did, however, point out that there can be tortious breach of contract but it is much different than the *Christian* cause of action. In doing so, the Court stated as follows:

> "We strongly agree that guarantor's primary contention that banks have an obligation to exercise good faith and fair dealing with its customers. The common law imposes the implied covenant upon all contracting parties, that neither party, because of the purposes of the contract, will act to injure the parties' reasonable expectations nor impair the rights or interests of the other to receive the benefits flowing from their contractual relationship. However, what guarantor fails to recognize is that in *Rodgers v. Tecumseh Bank,* this Court held that without 'gross recklessness or wanton negligence on behalf of a party' to a commercial contract, a breach of the

implied covenant of good faith and fair dealing merely results in a breach of contract.

We made it clear in *Rodgers*, that our seminal holding in *Christian v. American Home Assurance Co.*, does not generally apply to the relationship between a bank and its customer. In *Christian*, this Court held that in an insurance context, a breach of the implied covenant of good faith and fair dealing by the insurance carrier 'gives rise to an action in tort for which consequential, and in a proper case, punitive damages may be sought' by the insured. In *Rodgers*, we emphasized the *special relationship* between an insurer and insured which differentiates insurance contracts from commercial contracts. Our reluctance to extend *Christian* and its progeny beyond the insurance field was also illustrated in *Hinson v. Cameron*, where this Court refused to apply *Christian* to an at-will employment relationship. Again, we refuse to expand our *Christian* holding to banking relationship.' At 509 (Emphasis Court's).

It is important to understand that although the *Christian* cause of action may have some principals in general contract law, it is not an extension of contractual law to insurance contracts but is a separate and distinct cause of action that applies only to insurance contracts, homes in on insurance contracts and is designed to regulate the insurance industry.

In addition to the *Christian* cause of action not extending to other contracts, it does not even extend to every individual entitled to payment under an insurance contract. In the case of *Allstate Ins. Co. v. Amick*, 1984 Ok. 15, 681 P.2d 362, the Oklahoma Supreme Court refused to extend the cause of action to the benefit of third party claimants. In that case, the plaintiff was a third party claimant seeking damages against an

Allstate insured under a compulsory liability policy. The plaintiff may eventually be entitled to insurance proceeds by virtue of their cause of action against the insured of Allstate Insurance Company. The Oklahoma Supreme Court found that they were not entitled to the benefit of a *Christian* type cause of action. In denying that cause of action to third party claimants, the Supreme Court made the following observation:

> "[12] Prior to *Christian*, we had recognized insurers' duty to act in good faith and fair dealing with its insureds only as far as handling claims by third parties against the insured. We recognize a duty to accept reasonable settlements and act in good faith toward the insured and for the breach of this duty we impose liability in excess of policy limits. *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co., Okl.*, 321 P.2d 685 (1985); *National Mutual Casualty Co. v. Britt*, 203 Okl. 175, 200 P.2d 407 (1948).
>
> "[13] In *Christian*, this recognized duty of dealing fairly and acting in good faith with the insured was simply applied to claims of the insured itself.
>
> "[14] This single duty of dealing fairly and in good faith with the insureds arises from the contractual relationship. In absence of the contractual or statutory relationship, there is no duty which can be breached.' *Allstate Ins. Co. v. Amick*, 1984 Ok. 15, 681 P.2d 362.

Again, we see from the above quote that the *Christian* cause of action has its roots firmly based in insurance law.

Finally, we see a close relationship between a *Christian* cause of action and statutory regulation. In *Christian* the Oklahoma Supreme Court stated as follows:

> "[20] With all due respect to the brethren of the federal bench, we find the obligation of an insurer to

its insured upon proper presentation of a valid claim under a disability policy, is not limited to the payment of money only.

[21] Our Insurance Code requires insurance companies to make *immediate* payment of claims. Title 36 O.S. 1971 § 4405 A 8, requires the following provision to be included as a standard clause in all individual accident and health policies:

'**TIME OF PAYMENT OF CLAIMS**: Indemnities payable under this policy for any loss . . . will be paid immediately upon receipt of due written proof of such loss.'

[22] This statutory duty imposes upon insurance companies to pay claims immediately, recognizes that a substantial part of the right purchased by an insured is the right to received the policy benefits promptly. Unwarranted delay precipitates the precise economic hardship the insureds sought to avoid by purchase of the policy.' *Christian*, 577 P.2d at 903.

Turning now from the McCarran-Ferguson test set out in *Pilot Life*, we turn to more recent pronouncements by this Court. In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), this Court determined that California's Notice-Prejudice Rule was saved from ERISA pre-emption. In doing so, it told us that we should apply a more supple test to determine whether or not a law is an insurance law. We look at this case and its analysis of California law because of the way that the Tenth Circuit has continued to take one small portion of the *Christian* opinion out of context. The *Christian* case quoted the case of *Gruenberg v. Aetna Insurance Company*, 9 Cal. 3d 566, 510 P.2d 1032 (1973), in adopting the cause of action we now discuss. That case in turn quoted two excess liability bad faith cases just as *Christian* did. Those cases were *Crisci v.*

Security Ins. Co., 66 Cal. 2d 428, 58 Cal. Rptr. 13, 426 P.2d 173 (1967) and *Comunale v. Traders and General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958). In *Comunale*, the Court stated in part, "There is an implied covenant of good faith and fair dealing in every contract (including insurance policies) that neither party will do anything which will injure the rights of the other to receive the benefit of the agreement.' *Comunale*, 328 P.2d at P. 2000. This was quoted in *Christian,* 577 P.2d at 904. Based upon this quote within a quote, the Tenth Circuit has declared *Christian* to be a general contract law. In reviewing the Notice-Prejudice Rule which is a common law rule developed just like the *Christian* tort, the Court was faced with an argument from the defense that the Notice-Prejudice Rule was a rule of general application because of similarity to the maxim that "law abhors a forfeiture'. This Court responded as follows:

> "It is no doubt true that divest California decisions bears out the maxim that 'law abhors a forfeiture' and that the Notice-Prejudice Rule is an application of that maxim. But it is an application of a specific order, a rule mandatory for insurance contracts, not a principal a court pliably employ when the circumstances so warrant.' At 1387.

Of course, this same thing can be said of the *Christian* cause of action. Obviously, there is an implied covenant of good faith and fair dealing in every contract. But the way it is applied in an insurance contract in Oklahoma is a law of a specific order. What this Court said about California's Notice-Prejudice Rule could also be said about the Oklahoma tort of insurance bad faith:

> "The rule, by its very terms, 'is directed specifically at the insurance industry and is applicable only to insurance contracts.' . . . , [O]ur survey of California

> law reveals no case where the state court applied the Notice-Prejudice Rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms prejudice to an 'insurer' resulting from untimely notice.' The rule thus appears to satisfy the common-sense view as a regulation that hones in on the insurance industry and does 'not just have an impact on [that] industry. *Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549. " At 1387.

Most recently this Court has completely abandoned the McCarran-Ferguson test for a new test. In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (April 02, 2003), this Court declared,

> "Today, we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law . . . which regulates insurance' under Section 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See *Pilot Life, supra,* at 50, *UNUM, supra,* at 368, *Rush Prudential, supra,* at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's law satisfies each of these requirements.' At 1478.

Found at Footnote 3 of the opinion is the most important aspect of this holding as it pertains to this inquiry. The Court goes back to discuss its ruling of *UNUM Life of America v. Ward, supra*, that we just discussed. In that opinion, this Court never reached the question of whether or not the Notice-Prejudice Rule had the affect of spreading the risk. It felt that the other two McCarran-Ferguson factors were securely met. This spreading the risk factors has always been, to a certain

extent, the most bothersome of the factors. However, this clarification and revisiting of the Notice-Prejudice Rule shows that Oklahoma's insurance bad faith meets this requirement. In Footnote No. 3 the Court declared,

> "While the Ninth Circuit concluded in *Cisneros v. UNUM Life Ins. Co.,* 134 F.3d 939, 945-946 (1998), aff'd in part, rev'd and remanded in part, *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 899, 119 S.Ct. 1380, 143 L.Ed 2d 462 (1999), that the 'Notice-Prejudice Rule does not spread the policyholders risk within the meaning of the first McCarran-Ferguson factor,' our test requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does require that the state law actually spread the risk. See *Ante*, at 1477-1478. The Notice-Prejudice Rule governs whether or not an insurance company must cover a claim submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial affect on the risk pooling arrangement between the insurer and the insured.' At 1478.

The case of *First Bank of Turley v. Fidelity Deposit Ins. Co. of Maryland*, 1996 Ok. 105, 928 P.2d 298, is one of the many cases where the Oklahoma Supreme Court declined to extend the *Christian* cause of action beyond the insurance context. In doing so, the Court stated,

> "A *Christian* claim rests on the insurer's implied-in-law duty to act in good faith and deal fairly with the insured to the end that policy benefits are received . . . The *Christian* cause of action crafted as it is from the insured/insurer relationship, flows not so much from the contract as it does from the law that attaches a

> cluster of implied-in-law duties to the insurer-insured status.' 925 P.2d at 307.

In other words, all of those laws that would dictate the terms under which an insurer would pay a claim are merged into the *Christian* doctrine.

The *Christian* cause of action satisfies both prongs of the new test created in *Kentucky v. Miller, supra.*

4. AS A SAVED INSURANCE LAW, THE OKLAHOMA CAUSE OF ACTION FOR INSURANCE BAD FAITH DOES NOT CONFLICT WITH ERISA'S REMEDIAL PROVISIONS.

Petitioner's basic argument is that only through state regulation can ERISA achieve its goals. "The basic goal of ERISA was the protection and enhancement of the delivery of promised benefits.' *Polk, ERISA Prac. and Lit.,* Section 1:01. In the case of *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989), the Court stated:

> "ERISA was enacted 'to promote the interest of employees and their beneficiaries in employee benefit plans,' *Shaw v. Delta Airline, Inc.*, 463 U.S. 85, 90 (1983), and 'to protect and contractual define benefits; *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. at 148. See generally 29 U.S.C. § 1001. (setting forth congressional findings and declarations of policies regarding ERISA). Adopting *Firestone*'s reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.' 489 U.S. at 113.

Unfortunately, that is exactly what happened. No one can state with a straight face that employees and their beneficiaries

enjoy more protection under ERISA than they did before ERISA was enacted and interpreted in the way that it has been.

In *Pegram v. Herdich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed. 2nd 164 (2000), this Court ruled that an HMO making a mixed medical and claims decision could not be held liable under 29 U.S.C. § 1109(a) for breach of a fiduciary duty. If the logic extends to pure claims decisions, we will have a situation where the insurance claims administrator is given fiduciary deference without the offsetting liability.

In *California Federal Savings and Loan Association v. Guerra*, 479 U.S. 272, 281, 107 S.Ct. 683, 93 L.Ed. 2nd 613 (1987), we are told that conflict preemption occurs when, although not expressly displaced by Federal statute, a state law regulation so conflicts with federal law, that the Supremacy Clause of the Constitution compels preemption. "Such a conflict occurs either because 'compliance with both federal and state regulations is a physical impossibility,' or because the state law stands 'as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.''

The *Christian* cause of action and its monetary damages compliment the ERISA scheme and its assurance of quick administrative appeal from a denial. The administrative process can rectify an overzealous initial decision or ratify denial as part of company policy. Those denials that are deemed actionable will be identified and hopefully discontinued. Then both insured and insurer will have benefit of an administrative process as suggested by the ERISA statute but one that will be meaningful, giving the insured a quick and efficient way to challenge the denial of benefits and the company a safeguard against wrongful denials because of misunderstandings, miscommunications, and improper interpretations. The only way for ERISA to properly meet its stated goal is for companies to face the type of sanctions and

insureds to have the type of relief contemplated by a *Christian* cause of action. Not only is *Christian* not preempted by ERISA for ERISA to meet its stated goal, a *Christian* cause of action is essential.

In the case of *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002, 73 L.Ed 2nd 647, Justice Rehnquist in his dissent first pointed out that from 1869 until 1944 insurance was completely under the governance of the states. After the U.S. Supreme Court held in *United States v. Southern-Eastern Underwriters Association*, 322 U.S. 533 (1944) that the business of insurance was part of interstate commerce, the Congress' quick response was the McCarran-Ferguson Act. The Court found that the purpose of the McCarran-Ferguson Act and the indispensable part of it was the contractual relationship between the insurer and the insured. That was the essence of 'the business of insurance.' Justice Rehnquist went on to state:

> "Central to this contractual relationship is the process of claims adjustment ' The determination of the actual payments to be made to the insured for losses covered by the insurance contract. **The key representation of the insurance company and the principal expectation of the policy holder is that prompt payment will be made when the event insured against actually occurs**. As one commentator has stated, 'Up until the time there is claim and payment is made the only tangible evidence of insurance is a piece of paper. In other words the real product of insurance is the claims proceeds. Selection of the prospect, qualifying him for coverage that suits his needs, delivery of a policy, collecting premiums for perhaps years, making changes in coverage to meet changing situations, all of these are but preambles to the one purpose for which the

> insured was secured, named to collect dollars if and when an unforeseen event takes place.' At 136. (Emphasis added).

Justice Rehnquist is exactly right. The sole business of insurance companies is to pay claims when a covered loss occurs. Beyond that all an insurance policy is is a piece of paper, a promise to perform should the need arise. It is the one thing that people purchase and hope they never have to use. It is precisely because of this that the Oklahoma Supreme Court determined that this contractual relationship should be treated differently than other contractual relationships where each party is trying to gain some form of commercial advantage.

Claims processing being the central piece of insurance business, it makes little sense to save all state insurance law except those that directly govern and most strongly *affect* the claims handling process. No law affects the claims handling process more than the implied covenant of good faith and fair dealing and its remedial and punitive provisions. It encourages the insurance company to handle the claim in the appropriate manner and compensates the insured when that does not happen. If the true test of whether or not an insurance law is saved from ERISA pre-emption is whether or not it affects the risk, then certainly the *Christian* cause of action passes that test with flying colors.

This Court stated in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 414 U.S. 645, 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), the following:

> "We have never assumed lightly that Congress has degradated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant

> state law. Indeed, in cases . . . where federal law is said to bar state actions in fields of traditional state regulation, we have worked on the 'assumption that the historical police powers of the state were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress'.'

That, of course, is the general rule of law that this Court will presume that traditional state regulatory law is not pre-empted by a Federal Act. In this instance, we have insurance law that is specifically saved from pre-emption. Yet unfortunately it appears that this Court did in fact assume that state insurance laws, otherwise saved from ERISA pre-emption, were nonetheless pre-empted when they provided remedies. The Court did so by predicting a fatal conflict between saved state insurance laws with remedies and ERISA. There is an illuminating Law Review article by Donald T. Bogan, *Protecting Patients' Rights Despite ERISA; Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 941 (2000), hereinafter Bogan, Protecting Patients' Rights) . This review supports the proposition that ERISA was never intended to comprehensively regulate non-pension employee benefits in any way, including by way of remedies, and that explains why the saving clause was enacted. As Mr. Bogan observed, the legislative history reveals that abuses in the pension industry lead to ERISA's enactment "to comprehensively reform the private pension industry. *Id* at 964, 967 N. 7. See also *Taggert Corp. v. Life and Health Benefits Admin., Inc.*, 612 F.2d 1208, 1211 (5th Cir. 1980). The majority of ERISA's substantive provisions, and this is reflected by its history, deal with funding, protection against insolvency, vesting, and protection of workers in case of insolvency - - these apply only to pension plans. Bogan, *Protecting Patients' Rights* at 974-975. Petitioner's counsel would add that the legislative history also

dealt with tax consequences and tax incentives to encourage savings by both employers and employees. Mr. Bogan demonstrates that "ERISA's legislative history provides no evidence that Congress seriously investigated, studied or debated any issue or concerns with non-pension employee benefit plans.' *Id.* at 927.

Mr. Bogan goes on to conclude, "[w]hile it is true that portions of ERISA apply to non-pension benefit plans, the statute certainly does not provide a complete and coordinated network of rules to govern non-pension employee benefits'. *Id.* at 973. *See also Id.* at 956-958. Bogan finally states that if the courts were to accept "[t]his new ERISA super-pre-emption doctrine [it would] create a glaring void in the field of welfare plan regulation because ERISA, with its detailed focus on pension issues, does not replace pre-empted state laws in the field of welfare benefit plans with any substantive federal regulation.' *Id.* at 986.

What laws regulate an insurance company under ERISA? If *Pegram v. Herdrich, supra*, is extended to all claims handling, then an insurance company is not exposed to any liability as a fiduciary. Thus, there appears to be no law within ERISA that regulates insurance companies. In his article, Mr. Bogan concluded by enacting the saving clause, Congress intended to confine pre-emption to pension plans "because ERISA provides a pervasive and coordinated regulatory scheme to govern pension plans and because the field of pension regulation does not have strong state-law roots.' *Id.* At 957. This conclusion seems most logical when you consider there is a dearth of ERISA substantive regulation of insurance. In essence, there are no insurance regulations in ERISA. There is a specific saving of state insurance law.

There is no real "conflict pre-emption' analysis in ERISA cases but there is a significant body in Medicare cases. The

lead case is *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3rd 496 (9th Cir. 1996). Certiorari was denied by the Supreme Court twice in this case. *Aetna Health Plans of California, Inc. v. Ardary,* 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed. 2d 174 (1977) and *Inland Health Care Group v. Ardary,* 520 U.S. 1251, 117 S.Ct. 2407, 138 L./Ed. 2d 174 (1977).

The Ninth Circuit recognized that *Heckler v. Ringer*, 466 U.S. 602 (1984), declared that any benefit quest must be through the federal administrative process. The Court went on to state, "Because the states are independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre-empt state-law causes of action. State law is pre-empted if the law actually conflicts with federal law.' At 501. The Court further went on to state that they "start with the assumption that the historic police powers of the states were not to be superseded by the federal act unless there was a clear and manifest purpose of Congress.' At 501 (Citation omitted both quotations). Finally, the Ninth Circuit stated,

> "[w]e find nothing in the legislature history to suggest that the Act was designed to abolish all state remedies which might exist against private Medicare providers for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. Indeed, the 'legislative history of both the statute establishing the Medicare program and the 1972 Amendments thereto provide specific evidence of Congress' intent to foreclosure review only of 'amount determination' . . i.e. those 'quite minor matters,' 118 Cong. Rec. 33992 (1972) (Remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.'' At 501 (Citations omitted)

Other cases holding similar state actions are not pre-

empted by the Medicare Act include *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D. N.Y. 1998), *Caputo v. United States Healthcare Sys.*, 1998 W.L. 80611 (E.D. Pa. 1998), *McCall v. Pacificare of California, Inc.*, 25 Cal. 4th 412, 21 P.3d 1189, 106 Cal.. Rptr. 271 (2001), *Plocica v. Nylcare of Texas, Inc.*, 43 F. Supp 2d 658 (N.D. Tex. 1999), *Green v. Aetna U.S. Healthcare, Inc.*, 2000 W.L. 1229226 (N.D. Cal. 2000), *Shands Teaching Hosp. and Clinics, Humans Medical Plan, Inc.*, 272 So.2d 341, Fla. App. Dist. 1999), and *Hofler v. Aetna U.S. Healthcare of Cal., Inc.*, 2002 W.L. 1467701 (9th Cir. 2002).

It seems that the reasoning in these cases apply equally well in the ERISA context.

CONCLUSION

For the reasons above, the Petition for Writ of Certiorari should be granted.

Respectfully Submitted,

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UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

SALLEE A. CONOVER,

Plaintiff-Appellant,

v. No. 01-5172

AETNA US HEALTH CARE, INC.;
AETNA LIFE INSURANCE COMPANY,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Oklahoma
(D.C. No. 00-CV-559-B)

Joseph F. Clark, Jr., Tulsa, Oklahoma, for Plaintiff-Appellant

Mark D. Spencer (Henry D. Hoss and Amy T. Kranenburg) of McAfee & Taft, P. C., Oklahoma City, Oklahoma, for Defendants-Appellees.

Before O'BRIEN and McWILLIAMS, Circuit Judges, and BRORBY, Senior Circuit Judge.

BRORBY, Senior Circuit Judge.

Ms. Sallee Conover appeals from a district court decision holding her state law bad faith claim is preempted under the Employee Retirement Income Security Act. *See Conover v. Aetna U.S. Healthcare, Inc.*, 167 F. Supp.2d 1317 (N.D. Okla. 2001). Ms. Conover argues her claim is not preempted because the Act saves "any law of any State which regulates insurance." *See* 29 U.S.C. § 1144(b)(2)(A). We exercise jurisdiction pursuant to 28 U.S.C. § 1291 and affirm.

Ms. Conover was a participant in a long-term disability insurance plan through her employer. The plan was administered by Aetna US Healthcare. Ms. Conover was injured in a car accident and submitted a claim to Aetna for disability benefits. Aetna approved her claim and began making monthly benefit payments to her. After further investigation, however, Aetna determined Ms. Conover could perform the material duties of her occupation and suspended her benefits. Ms. Conover responded by filing this lawsuit in Tulsa County District Court, alleging intentional breach of contract and bad faith. The bad faith cause of action was based on Oklahoma state law. Aetna removed the case to the United States District Court for the Northern District of Oklahoma.

A few months later, Aetna reviewed additional information regarding Ms. Conover's claim for disability benefits and determined she remained eligible for the benefits. Aetna reinstated her benefits and paid all back benefits due. This rendered moot Ms. Conover's cause of action for intentional breach of contract. Around the same time, Aetna moved the district court for a determination regarding preemption under the Employee Retirement Income Security Act. In addressing the motion, the district court ruled the Act preempted Ms. Conover's bad faith cause of action. *See Conover*, 167 F. Supp.2d at 1318-21. The court subsequently entered final judgement for Aetna, and Ms. Conover appeals.

Ms. Conover argues her bad faith claim is not preempted

under the Employee Retirement Income Security Act.[2] We review this question de novo because it involves an issue of law. *See Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 989 (10th Cir. 1999).

The Employee Retirement Income Security Act preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Act, however, saves from preemption state laws "regulat[ing] insurance." 29 U.S.C. § 1144(b)(2)(A). In determining whether a state law regulates insurance, we follow the two-step inquiry set forth by the Supreme Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). We first inquire whether, from a "common-sense view of the matter," the state la regulates insurance. *Id.* at 740; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987). We then test this result against three factors derived from case law interpreting the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) & (b): "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (quotation marks and citation omitted); *Pilot Life*, 481 U.S. at 4849. All three McCarran-Ferguson factors need not be met in order for a state law to regulate insurance. *See Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, _____ , 122 S. Ct. 2151, 2163 (2002); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999). Instead, these factors should be "weighed" and serve as "guideposts" in determining whether a state law regulates insurance. *Rush*

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[2] Ms. Conover also argues the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), permits us to award extra-contractual damages in Employee Retirement Income Security Act actions, including mental anguish and punitive damages. This argument is foreclosed by our decision in *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822, 827-829 (10th Cir. 1995).

Prudential, 122 S. Ct. at 2163; *Ward*, 526 U.S. at 373-74. If after applying this two-part inquiry, we are satisfied the state law regulates insurance, it is saved from preemption under the Act. See 29 U.S.C. § 1144(b)(2)(A). This does not, however, end our preemption analysis.

A state law otherwise regulating insurance within the meaning of § 514(b)(2)(A) may still be preempted if it allows plan participants and beneficiaries "to obtain remedies under state law that Congress rejected in [the Employee Retirement Income Security Act]." *Pilot Life*, 481 U.S. at 54, 57; *Rush Prudential*, 122 S. Ct. at 2165.[3] The Act sets forth "'six carefully integrated civil enforcement provisions.'" *Pilot Life*, 481 U.S. at 54 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). See also 29 U.S.C. § 1132(a). Under these provisions, a plan participant or beneficiary may bring a civil action to recover benefits due, enforce rights, or clarify future benefits under the terms of the plan. See 29 U.S.C. § 1132(a)(l)(B). A plan participant or beneficiary may also bring an action to enforce provisions of the plan or Act, to enjoin or redress violations of the Act, or to

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[3] Ms. Conover suggests the Supreme Court impliedly overruled this portion of the *Pilot Life* decision in *Ward,* 526 U.S. at 376 n.7. We disagree for three reasons. First, the Supreme Court instructed us to avoid concluding its "more recent cases have, by implication, overruled an earlier precedent." *Agostini v. Felton*, 521 U.S. 203, 237 (1997). Rather, we "should follow the case which directly controls, leaving to [the Supreme] Court the prerogative of overruling its own decisions." *Id.* (quotation marks and citation omitted). Second, the Court in Ward noted but did not address the Solicitor General's argument that *Pilot Life* does not hold a state law regulating insurance is nevertheless preempted if it provides a state law cause of action or remedy. See *Ward*, 526 U.S. at 376 n.7. Third, the Supreme Court reaffirmed this portion of the *Pilot Life* decision in a later decision, stating a state law is preempted if it "allows plan participants to obtain remedies ... that Congress rejected in [the Employee Retirement Income Security Act]." *Rush Prudential*, 122 S. Ct. at 2165 (quoting *Pilot Life*, 481 U.S. at 54).

remove the fiduciary for breach of fiduciary duty. See 29 U.S.C. §§ 1132(a)(1)(A), 1132(a)(3), and 1109(a). In an action under these civil enforcement provisions, a court may, in its discretion, award attorney's fees and costs to either party. See 29 U.S.C. § 1132(g)(1). The Supreme Court held these civil enforcement provisions are "exclusive." *Pilot Life,* 481 U.S. at 52, 54. Therefore, if a state law "add[s] to the judicial remedies" available under the Act, the law is preempted. *Rush Prudential*, 122 S. Ct. at 2166.

It is undisputed Oklahoma's bad faith law falls within the Employee Retirement Income Security Act's language preempting state laws related to "any employee benefit plan." 29 U.S.C. § 1144(a). Oklahoma's bad faith law imposes on insurers "an implied duty to deal fairly and act in good faith with its insured." *Christian v. American Home Assurance Co.*, 577 P.2d 899, 904 (Okla. 1977). A "violation of this duty gives rise to an action in tort for which consequential and, in a proper case, punitive, damages may be sought." *Id.* Ms. Conover argues Oklahoma's bad faith law is saved from preemption under the Act because it "regulates insurance." See 29 U.S.C. § 1144(b)(2)(A). We disagree. This court addressed this issue in *Gaylor v. John Hancock Mutual Life Insurance Co.*, 112 F.3d 460, 466 (10th Cir. 1997), holding "Oklahoma's bad faith law does not sufficiently regulate insurance such that it falls within [the Act]'s saving clause." We are bound by this decision. See *Burlington N. & Santa Fe Ry. Co. v. Burton*, 270 F.3d 942, 947 (10th Cir. 2001), *cert denied*, 122 S. Ct. 2664 (2002).

Ms. Conover nonetheless suggests Oklahoma's bad faith law regulates insurance from a common-sense view because it "homes in on the insurance industry." See *Ward,* 526 U.S. at 359. We disagree. Even though Oklahoma's Supreme Court has associated its bad faith law with the insurance industry, "its origins are from general principles of tort and contract law." *Gaylor*, 112 F.3d at 466. Oklahoma's Supreme Court also recognized "'[t]here is an implied covenant of good faith and fair dealing in every contract.'" *Christian*, 577 P.2d at 904

(quoting *Gruenberg v. Aetna Ins. Co.*, 108 Cal. Rptr. 480, 484 (Cal. 1973)). Breach of any contract, and not just an insurance contract, may lead to liability in tort under Oklahoma law. See, e.g., *Beshara v. Southern Nat'l Bank*, 928 P.2d 280, 291 (Okla. 1996) ("When the factual situation warrants, an action for a breach of contract may also give rise to a tort action for a breach of the implied covenant of good faith and fair dealing."). Consequently, Oklahoma's bad faith law does not home in only on the insurance industry. See *Moffett v. Halliburton Energy Servs., Inc.*, 291 F.3d 1227, 1236 (10th Cir. 2002).

Ms. Conover also argues *Gaylor* is not controlling because it "rigidly applied" the McCarran-Ferguson factors, putting "undue emphasis on the [first McCarran-Ferguson] requirement that a law spread the risk among policy holders n order for it to qualify for the [Employee Retirement Income Security Act] saving clause." She claims a more "pliable approach" should be used in light of the subsequent Supreme Court decisions in *Rush Prudential* and *Ward*. The Court in these decisions clarified "the McCarran-Ferguson factors are considerations [to be] weighed in determining whether a state law regulates insurance"; a state law need not "satisfy all three McCarran-Ferguson factors in order to regulate insurance." *Ward*, 526 U.S. at 373 (quotation marks and citation omitted). See also *Rush Prudential*, 122 S. Ct. at 2163.

While we, of course, agree all three McCarran-Ferguson factors need not be satisfied for a state law to regulate insurance, *see Moffett*, 291 F.3d at 1236, we disagree with Ms. Conover's suggestion these later Supreme Court decisions undermine our holding in *Gaylor*. The *Gaylor* court did not put "undue emphasis" on any particular McCarran- Ferguson factor in reaching its decision. Instead, the court concluded Oklahoma's bad faith law did not meet the first and second McCarran-Ferguson factors, and the third factor was undermined because the law's origins were "from general principles of tort and contract law." *Gaylor*, 112 F.3d at 466. In contrast, the Supreme Court in both *Rush Prudential* and

Ward held the saving clause to apply, even though the first McCarran-Ferguson factor was arguably not met, only after finding the other two factors were "clearly" or "securely" satisfied. *Rush Prudential*, 122 S. Ct. at 2163; *Ward,* 526 U.S. at 364.[4]

Furthermore, the court in *Gaylor* concluded Oklahoma's bad faith law provided a cause of action excluded from the Employee Retirement Income Security Act's civil enforcement scheme and would therefore "pose an obstacle to the purposes and objectives of Congress." *Gaylor*, 112 F.3d at 466 (quoting *Pilot Life*, 481 U.S. at 52) .[5] Oklahoma's law allows plan participants to obtain "consequential and, in a proper case,

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[4]Even after the Supreme Court's decision in *Ward,* this court reaffirmed that a state law does not regulate insurance if it does not meet the first two McCarran-Ferguson factors, and the third factor is undermined because the law (although associated with the insurance industry) has its roots in tort and contract law. *See Moffett*, 291 F.3d at 1236-37.

[5]Ms. Conover disagrees, arguing Oklahoma's bad faith law does not conflict with the Employee Retirement Income Security Act's civil enforcement scheme. Ms. Conover claims "[t]he only way for [the Act] to properly meet its stated goal is for companies to face the type of sanctions and insureds to have the type of relief contemplated by [Oklahoma's bad faith law]." Once again, however, Ms. Conover's argument is foreclosed by our decision in Gaylor, 112 F.3d at 466. Ms. Conover's argument is also contrary to Supreme Court decisions holding the Act's civil enforcement scheme is exclusive. See Rush Prudential, 122 S. Ct. at 2165-66; Ingersoll-Rand, 498 U.S. at 144; Pilot Life, 481 U.S. at 52, 54; Russell, 473 U.S. at 146.

punitive, damages" for breach of good faith and fair dealing by an insurer. *Christian*, 577 P.2d at 904. Nowhere does the Employee Retirement Income Security Act allow consequential or punitive damages. Damages are limited to the recovery of "benefits due ... under the terms of the plan." See 29 U.S.C. § 1132(a)(1)(B). Oklahoma's bad faith law therefore "allows plan participants to obtain remedies ... that Congress rejected in the Act." *Rush Prudential*, 122 S. Ct. at 2165 (quoting *Pilot Life*, 481 U.S. at 54) (quotation marks omitted).

In sum, we conclude *Gaylor* still controls the resolution of this case. Oklahoma's bad faith law is not saved from preemption under Employee Retirement Income Security Act because it does not "regulate[] insurance." 29 U.S.C. § 1144(b)(2)(A). Oklahoma's bad faith law is therefore preempted because it "relate[s] to an employee benefit plan" and conflicts with the Employee Retirement Income Security Act's civil enforcement scheme. *See* 29 U.S.C. §§ 1144(a) and 1132(a). We AFFIRM the district court's decision.

11 UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

SALLEE A. CONOVER,

Plaintiff - Appellant,

v. No. 01-5172

AETNA US HEALTH CARE, INC.;
AETNA LIFE INSURANCE COMPANY,

Defendants - Appellees.

ORDER

Filed March 21, 2003

Before O'BRIEN, Circuit Judge, McWILLIAMS and BRORBY, Senior Circuit Judges.

Appellant's petition for rehearing is denied.

The petition for rehearing en bane was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court
PATRICK FISHER, Clerk of Court

by: s/
Deputy Clerk

APPENDIX

29 U..S.C.A. § 1001

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE A - GENERAL PROVISIONS

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce I and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect

to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension

plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C.A. § 1132

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE B - REGULATORY PROVISIONS
PART 5 - ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the he Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this

section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title[6] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has

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[6] So in original. Probably should be "subtitle".

not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if -

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 119lb(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable

to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material

requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to 8100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1.320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district

courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretionmay allow a reasonable attorney's ee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan -

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of -

(i) interest on the unpaid contributions,

or

(ii) liquidated damages provided for under the plan n an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph

(A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5)

of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of -

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a

breach or violation described in paragraph (1) -

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that -

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

29 U.S.C.A. § 1144
UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B - REGULATORY PROVISIONS
PART 5 - ADMINISTRATION AND ENFORCEMENT

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State

purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section

(i) any State tax law relating to employee benefit plans, or

(fi) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section -

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully

insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides -

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully

insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action -

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only

to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.